**ABSTRACT**

SOCIAL WORK

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A STUDY OF THE EFFECTS
OF PLANNED INTERVENTIONS ON
A LONG-TERM INSTITUTIONALIZED PATIENT

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The purpose of this study was to assess the success of application of therapeutic interventions on discharge planning for patients who have been "institutionalized" (behaviorally conditioned to function within the norms of a facility and the internalization of the norms after extended dependent associations with the facility. The interventions used were a therapeutic level system, day treatment, and dedicated case-management. It was hypothesized that the appropriate use of these interventions would greatly improve the discharge planning of a patient suffering the debilitating effects of anxiety reactions to separation from the hospital. The research found that when properly utilized, the patient was able to successfully be discharged from the hospital and his overall affect and behavior were greatly improved.

# A STUDY OF THE EFFECTS OF PLANNED INTERVENTIONS ON A LONG TERM HOSPITALIZED PATIENT

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# CHAPTER I
# INTRODUCTION

The move towards community wide care as opposed to large inpatient facilities, formally known as "deinstitutionalization", though very well intended, has created a latent problem of what to do with patients who have assimilated to develop a condition known in clinical circles as "institutionalizion". That is to say that these individuals have become behaviorally conditioned to function within the provided norms of a facility and the internalization of these norms after extended dependent associations with the facility.

A major problem facing inpatient facilities is the cycle of recidivism. Patients with chronic illnesses such as schizophrenia, bipolar illness, or some form of addictive disorder frequently are admitted, discharged, and readmitted.

Deinstitutionalization has been described as a phenomenon concerned with exchanging the location of patients' care. Frequently the success of deinstitutionalzation is measured in terms of whether patients are being treated in or out of an institution. Those in the field of psychiatric rehabilitation expand the criterion for measuring the success of the policy to include not only where patients live but also their degree of success in that setting. The responsibility of professionals providing services for chronic patients should shift from merely discharging patients from the facility to providing the substantial discharge planning process that will

not only prepare the patient for release, but that will either dramatically increase the time between hospitalizations or eliminate the need for such cyclical life styles of these chronic patients. The latter being ideal.

## Statement of the Problem

Deinstitutionalization dramatically affected the inpatient psychiatric population from 1950 to 1980. National Institute of Mental Health (NIMH) data indicate that in 1950 there were 512,501 psychiatric inpatients in 322 state and county facilities. By 1980, that number had decreased to 137,810 inpatients in 275 facilities. The dramatic and steady decrease of inpatients in psychiatric centers from 1963 to 1980 constituted a 72% reduction of the institutionalized mentally ill population from 504,604 to 137,810, or a decrease of 366,794 patients.[1]

Typically, expectations are low for these patients. Everyone has heard the horror stories of mentally ill patients being given bus tickets to large metropolitan areas as part of their discharge plan. Although this is fortunately a past blight on the mental health delivery system, similar injustices have be substituted. Instead of a one way bus ticket to the nearest large city, patients are given referrals to local mental health centers that are underfunded, understaffed, and essentially what amounts to a round trip ticket back to the inpatient facility. Quite often is the

case that each hospitalization for chronic patients is for restabilization on medication in order to once again discharge the patient back to the community.[2]

The development of psychopharmacology was a major turning point in the history of the treatment of mental illness and the delivery of psychiatric services. Psychotropic medication enabled thousands of mentally ill persons who had been hospitalized prior to the availability of these medications to function at a level that made discharge from the psychiatric hospital and community placement possible, albeit with varying degrees of success. However, the miracles that psychotropic medications were expected to perform were overestimated. It is now acknowledged that side effects and the lack of predictable outcomes have dramatically limited the use of psychotropic medications in specific situations.[3]

Chronically mentally ill patients all share on unfortunate commonality. This is the ever present phenomenon of "cycling". That is to say that their lives are marked by continuously recurring periods of acuity, or severity of symptoms. This should be considered as fact when both actively treating or discharge planning for chronic patients. Most mental illnesses - especially chronic mental illnesses - are cyclical. That is, the person for whom the discharge planner plans is different from the one who was first admitted to the mental health service or facility. Perhaps even more significant, this person is different from the one the client

will become when and if he or she becomes ill again. Furthermore, there is no accurate way to predict when the changes may occur, how dramatic they will be, or whether previously effective treatment will work again.[4]

This is the nature of chronic mental illness. Therefore, discharge planners should focus on increasing the time lapse between hospitalizations. One tool is to assist the patient in developing healthy coping skills in order to more effectively adjust to being out of the hospital. This to say, increasing the patient's ability to appropriately cope with anxiety without resorting to his or her usual phobic reaction. The goal, after all, is return to the community with skills to adjust to the extent necessary to effect some semblance of normalcy. Mental health professionals also have a moral commitment to provide as much freedom from restriction as the client can manage (i.e., place him or her in the least restricting environment possible). Experience has shown that institutionalization and dependency compound the problems of the mentally; therefore, freedom and support must be carefully balance for each client each time he or she is placed in a setting.[5]

Thus, it becomes necessary to evaluate activity both in terms of achievable objectives and efficiency in that achievement.

The concept of the interdisciplinary team approach will be discussed in more detail within the methodology section of

this work. The message intended at this point is that creating a good treatment plan is like painting by numbers. The job of the interdisciplinary team is to place the various colors in such a way that they coordinate to form a complete patient care picture.

The essential components that inhibit independent functioning are: prolonged hospitalization, agoraphobia, depression, and hospital policy. This leads to a problem statement of how to effectively apply innovative interventions to facilitate successful discharge planning for long term hospitalized patients within the framework of a system with large catchment areas such as that of Georgia Mental Health Institute (GMHI).

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2. Ibid., 58.

3. Brown P, Kochansky G, Shaprio R, (1981) Overview: deinstitutionalization of psychiatric patients: a critical review of outcome studies. American Journal of Psychiatry. 138: 736-749.

4. O'Sullivan, A. and Brody, M. (1986) Discharge planning for the mentally disabled. Quality Review Bulletin, 55.

5. Ibid., 56

# CHAPTER II
## Literature Review

At the end of 1981 there were two-thirds fewer patients in the state and county mental hospitals in the United States than there had been at the end of 1969, continuing a trend that had begun shortly after the peak year of 1955. The trend will undoubtedly continue, although perhaps at a slower rate, it's common knowledge that increasing number of problems associated with too early and insufficiently stringent releases of mental patients into communities ill-equipped to deal with them. The dramatic decline in occupied mental hospital beds has been due to several factors, including (a) introduction of a host of potent drugs that suppress severe mental symptoms; (b) recognition of the debilitation and antitherapeutic effects of long term hospitalization and the attendant deinstitutionalization movement; (c) introduction of community mental health centers and related community facilities to care for individuals needing continued treatment on an out-patient basis; and (d) increased availability of alternate care facilities, such as nursing homes for the aged.[1]

After years upon years of inhumanly warehousing individuals for decades who were afflicted with mental illness, mental health professionals today are left to deal with the results of their forerunners' era of providing care.

There has indeed been a significant reduction in hospital

populations: from over 559,000 in 1955 to around 214,000 in 1981. A number of factors have interacted to alter the pattern of mental hospital admissions and discharges over the past 25 years. As has been noted in many studies, the introduction of the major tranquilizers made it possible for large numbers, of patients, who would formerly have required confinement, to be released to the community. The availability of tranquilizing medications led many to believe (falsely) that all mental health problems could be managed with medication. In addition, the changing treatment philosophy and the desire to eliminate mental institutions was accompanied by the belief that society wanted and could financially afford to provide better community-based care for chronic patients outside the large mental hospital.[2]

The recidivision rate at GMHI is testimony that this approach of stabilizing chronic patients on some form of medication only to discharge them back to the risk factors which triggered their relapse to begin with. There are many factors that virtually leave facilities such as GMHI to adapt this acute stabilization approach. But, the most contributory factor is money. Actually, the lack of resources is more exact. Typically, clients served by GMHI, and any state hospital, are people who have no health insurance that would allow access to private hospitals with the budget necessary to provide the type of care required for such a population.

Gains in the level of patient care have come at a cost.

In 1970, states spent less than $5,000 per year to care for each patient at the state hospital; by 1982 they were spending more than $30,000 per patient per year. Of course, the state hospital population was much sicker in 1982 than it was in 1970, which may account for at least some of the increased costs.

Mental illness has not fared well in the mainstream of general care. The Medicare program is certainly a case in point. Less than 2 percent of Medicare expenditures are devoted to the treatment of mental illness despite extremely high mental health needs and levels of disability in this population. Even the Medicaid program, which is specifically oriented toward the treatment of mental illness on a nondiscriminatory basis in general hospitals, expends less than 10 percent of its dollars on psychiatric services.[3]

Yet another factor plays into the routine type of care received in state run facilities, and that is a rapid rate of admissions. This dictates that decisions on readiness for discharge are often made out of necessity, not patient stability. In situations such as this, the patient who presents as less acute in the facility, is most likely to be discharged.

One of the most significant problems in the maintenance of discharged patients outside the hospital involves preventing the individual from developing what has been referred to as the "chronic social breakdown syndrome". This

pattern of maladaptive behavior involves the individuals failing to maintain his or her self-care and social functioning skills at the level he or she attained prior to discharge from the hospital. While maintenance on tranquilizing drugs will help the individual to cope, it is important that assistance be provided to help maintain or attain an adequate social adjustment. This assistance or continuing care in the community can provide the patient with needed structure while he or she is learning new responsibilities and roles that are required in the new living situations.[4]

Deinstitutionalization also was a process that described the ongoing change, readjustment, and redefinition of all components of the mental health delivery system. One of its major goals was to develop a multimodel pluralistic system of community care; such a system affords people psychiatric care in the lease restrictive setting while also providing protective and supportive environments when necessary. This system has been slow in developing and is still far from being fully realized because of local community reasons, continuing lack of knowledge regarding what does and does no work for the mentally ill, lack of a cohesive grassroots advocacy group, fear and misunderstanding of the mentally ill, and the changing make-up and needs of the mentally ill population.[5]

It would be prudent at this point to mention that large inpatient acute care facilities remain an important resource

both for provision of services when needed for treatment and stabilization and for continuing research in medications and therapeutic techniques for the advancement of the entire treatment arena. The question is not what to do with institutions themselves, but what to do to curve the effect that extended stays, which are quite frequently needed, have on individuals who have internalized the structure to a point that separation from the facility causes the patient to suffer extreme anxiety or other debilitating emotional\affectual discomfort.

Thus from the perspective of discharge planning and community placement, the group within the long-stay population identified as the young-adult-chronic patient probably presents the most significant challenge to the mental health system. This group presents an array of issues that the traditional mental health system has not previously had to handle. Pepper states:

> Although they [the issues] present a variety of symptom profiles, they share two overarching characteristics: Their severe difficulties in social functioning and their tendency to use mental health services inappropriately in ways that drain the time and energy if clinicians yet do not conform to viable treatment plans.[6]

These developments imply that, contrary to a view held in the late 1960s, the large public institution providing inpatient care for the mentally ill is not extinct; it continues to be a necessary resource for treatment despite all of the deinstitutionalization efforts. Also, many state

hospitals have developed from facilities that treat a largely homogeneous population of long-stay schizophrenics and now serve a smaller proportion of the original clientele. In addition, they currently serve a larger number of patients who are young male schizophrenics and substance abusers as well as elderly patients who no longer exhibit active psychiatric symptomatology.[7]

It is these individuals who become caught in the so called "revolving door" of state hospital treatment. While effectively, and efficiently, providing a sound pharmaceutical milieu, (treatment environment), that satisfies the stabilization component of inpatient psychiatric care, they're falling short of addressing substantially the patient's uniquely relevant life situation or equally important the impact that such a concomitant relationship has on the lives of patients who are latently conditioned to function best within a closed clinical environment.

Dickey and colleagues followed the cases' 54 patients in hospital wards where it had been administratively decided that most of the patients housed on 2 locked units would be moved to community settings. A plan was developed to move the two populations through increasingly independent living environments with the expectation that some would eventually live on their own without supervision. The hospital and participating community mental health centers attempted to establish a range of living environments for the patients,

such as quarterway houses, halfway houses, and supervised apartments, that would form a bridge between the hospital and the community.[8]

Two of the patients died during the follow-up period, and all but one of the remaining 52 patients were successfully followed. Their residential status had been corroborated by hospital or community treatment personnel. The number of patients noted requiring inpatient readmittance dropped from the original 54 to 30, a drop of 44 percent.[9]

The most fundamental and pervasive issue in planning for the discharge and placement of the mentally ill patient is balancing the client's need for stability and security against the need for independence and unrestricted functioning. Although the needs and resources relevant to each individual situation must be analyzed, everyone requires some degree of continuity in his or her relations and in such fundamental aspects of his or her life such as living arrangements and financial security, in order to function well. Stability and consistency are vital for the mentally disabled person, whose very illness is often characterized by severe difficulties with trusting, forming lasting relationships, and an inability to cope with frustrations and problems.[10]

Conversely, stability and consistency can translate into overdependence on others or a restricted view of the world that may contribute to overdependence. The discharge planner must maintain a reasonable degree of stability and consistency

without totally extinguishing the spark that encourages the degree of risk taking necessary for a normal existence. The discharge planner will also be forced to deal with other issues such as public relations to the mentally ill and fiscal constraints. The mentally ill have no real constituency to advocate for them; therefore, the services provided for them are often easy targets of a budget crunch.[11]

The social psychological, and demographic variables that must be considered in discharge planning range from ascertaining the availability of adequate housing, being sensitive to the attitudes of the community toward mentally ill persons, and determining whether occupational and leisure-time activities are accessible to the client to being sensitive to the racial and ethnic characteristics of both the client and the community.[12]

Farkas and associates followed patients for a period of five years beginning in February 1979 and ending in March 1984. Data collected were diagnosis, age, sex, length of hospitalization, and use of medication. Changes in their residential and vocational status and life skills were assessed. Residential status was noted using the Location Status Index, an 8-point scale that measures the degree of independence of the psychiatric patient's living arrangement. The more independent the living arrangement the higher the living arrangement the higher the rating; i.e., a locked unit would receive the lowest rating, an unlocked unit would

follow, etc., and living independently would receive the highest rating. Living independence was assessed seven times in a period covering five years, starting in February 1979, and ending in March 1984.[13]

Although there was some relationship between residential status and vocational status, the only patients whose vocational independence was limited by their residential status were those living in locked wards, who were not allowed free access to vocational activities. All of the other patients, however, had the opportunity to participate in all of the vocational activities.[14]

These findings reinforce the assumption that patients housed in locked units are limited in their exposure to necessary resources to adequately afford them the opportunity to be re-introduced into the community with an acceptable expectation of success. The implication is that even those patients that are treated in the most restrictive environment should have at least supervised exposure to community resources during the discharge planning phase of inpatients care.

## Theoretical Framework

The behavioral approach had its origin in the 1950's nad early 1960's as a radical departure from the dominant psychoanalytic perspective. One trend in behavior therapy is that of operant conditioning. Operant behavior consists of actions that operate on the environment to produce

consequences. If the environmental changes brought about by the behavior are reinforcing (providing some reward to the organism or eliminate aversive stimuli), then the chances are strengthened for the behavior to occur again.[15]

Since the patient is this study's anxiety and depression are manifested in behavior such as social isolation, sabotaging discharge attempts by verbalizing suicidal ideation, and his mood is consistently hopeless and disheveled, a behavioral approach utilizing the classic theories of B.F. Skinner is most appropriate.

Skinner contends that learning cannot occur in the absence of some kind of reinforcement, either positive or negative. To Skinner, actions that are reinforced tend to be repeated, and those that are discouraged tend to be extinguished. Positive reinforcement involves the addition of something (such as praise or money) as a consequence of certain behavior. Negative reinforcement involves the removal of unpleasant stimuli from a situation once a certain behavior has occurred. Skinner's general writings apply concepts of operant conditioning (operant consisting of actions that operate on the environment to produce consequences) to society. Skinner's model is based on reinforcement principles and has the goal of identifying and controlling environmental factors that lead to behavioral change.[16]

Since the basis of Mr. X's issues are that of conditioned responses to situational adjustments it is imperative that a

framework that concentrates on both understanding these responses and manipulating them so that they will benefit the patients in a more acceptable manner. Neo-Freudians such as Weiss and Anna Freud agree that in cases where clients are resulting to primitive adaptive behavior the focus of treatment should be that of a gradual reconditioning which the client is confronted with the source of anxiety and give both alternative ways of problem solving and methods of decreasing the effect that the anxiety will have on the client's ability to function in spite of situational frustration.

## Purpose of Study

The purpose of this study was to explore alternative ways of discharge planning for long-term hospitalized patients that would be applicable with in a rigid system such as GMHI. The goals were; to address the patient in such a way that the patient is actually making decisions along with the social worker, to increase the patients expectations of himself, to increase the patients ability to function independent of the hospital, and to assist the patient in accessing the available community resources that would enable him to attend to activities of daily living free of extreme frustration and anxiety.

## Definition of Terms

Agoraphobia - An irrational fear of being separated from a recognized area of safety. This is usually the place of residence.

Anxiety - Apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external.

Chronic - Marked by long duration or frequent recurrence of symptoms.

Concomitant - To exist in a collaterally connected way with something else.

Cycling - The recurrence of symptoms after a brief period of recovery that occurs in chronic mental illness.

Institutionalized - Behaviorally conditioned to function within the structure of a facility and the internalization of the structure after extended dependent association with the facility.

Neurotic - A response in which the predominant disturbance is a distressing symptom or group of symptoms which are considered unacceptable or alien to one's personality. An extreme reaction to stress that maintains a group on reality.

Pathological - A process of progressive deviation from what is called normal which is considered destructive.

Pharmaceutical - A treatment approach centered around the use of medication and the monitoring of its effects on patients.

Phenomenon - An exceptional or unusual fact or event that calls for scientific investigation.

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9. Ibid., 329.

10. Ibid., 328.

11. Ibid., 66.

12. Ibid., 56.

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16 Ibid., 177.

# CHAPTER III
# METHODOLOGY

The single system research design was chosen for this work because of its ability to assess the effectiveness of the intervention as well as total outcome. Basically, a single system research design refers to the repeated collection of information on a "single system" over time.

The type of single system design chosen is the basic A-B design. The A-B design is often seen as the foundation of singly system design because of the basic distinction between, and the combining of, a baseline observation period A, and intervention period, B.[1]

## Setting

The actual setting for this study was unit 6 (Forensic Services Unit) at GMHI. Forensics services means those mental health and mental retardation services, including but not limited to diagnostic, evaluative, treatment and habilitation services, provided to forensic patients. The people being evaluated may be found incompetent to stand trial, not guilty by reason of insanity, guilty but mentally ill or guilty but mentally retarded. Forensic services differ from standard GMHI service units in that the admission and discharge of forensic patients is controlled by a court.

The mission of the Forensics Services Unit at GMHI is to provide and promote the services necessary for evaluation and

treatment or habilitation of persons ordered to the Department of Human Resources as a result of special proceedings within the criminal justice system.

The census of the unit is controlled by the rate of admissions from the courts. Although the capacity of the unit is recognized as 23 patients, it isn't uncommon for the census to well exceed this or at periods to even fall well below that figure. The average census is 22 patients.

A "forensics" patient is a person who has been charged with a violation of state law and who is admitted to a state operated hospital under order of a state court or superior court. The court order may provide for diagnostic, evaluative, treatment or habilitation service before or after disposition of the criminal charges.

**Patient History**

Mr. X is a 36 year old Black male presented secondary to a failed discharge attempt. Mr. X presented as rigid and abrupt in his responses during interview. Mr. X was re-admitted one day after being discharged to the community via the Union Mission in Atlanta, Georgia. The Union Mission is a non-profit transitional housing program that assist, homeless individuals and families in placement, job training, re-education, and financial assistance. Mr. X was informed of the discharge plan and then discharged from GMHI to the mission. Mr. X was given bus fare, directions with bus routes

and instructions to take the bus to the mission and check in. The Union Mission was contacted by the unit social worker and informed of the client needs, and Mr. X's discharge planning was complete.

Mr. X was a patient on the Forensics Services Unit at the Georgia Mental Health Institute. "Forensics Services" being those mental health and mental retardation services, including but not limited to diagnostic, evaluative, treatment and habilitation services, provided to forensics patients. The term may include consultation and education provided to the criminal justice system, as appropriate. It also includes evaluations of individuals as ordered by the courts. The term includes but is not limited to persons who are incompetent to stand trail, who are not guilty by reason of insanity, guilt but mentally ill, or guilty but mentally retarded.

Mr. X began displaying symptoms of the precursors of mental illness at about age 9 years. Mr. X was twice suspended from elementary school for fighting and eventually expelled from the Brooklyn Public School for the same, all in one school year. Mr. X reports that after staying out of school for a year his mother attempted to enroll again into the fourth grade, he went for only a few month and then stopped all together.

Mr. X is the middle child in a sibling system of three. He has an older sister and a younger brother. The family has

lived in Brooklyn, New York since the patient's mother and father, moved there from South Carolina. Prior to having any of the children Mr. X's parents were never legally married, but they were together until the Mr. X's father left looking for work when the patient was eight year old and never returned. He died in 1972. The patient never saw his father again.

Mrs. X decided to take the patient to Georgia to live with her sister after he was arrested for attempted rape and convicted. Mr. X won his freedom on appeal, but at age 15, his mother had given up hope that he would be free for long if he stayed in New York. He was driven from Brooklyn and left with his aunt whom he hadn't seen since he was a toddler. The patient's aunt, was already 53 years old and alone since her husband had died. Mr. X reports that it was here that he began to use heroin and cocaine on a regular basis. He was soon arrested in 1974 for armed robbery. He served 7 years.

After his release from prison, Mr. X states that, "I started being by myself a lot, and having crazy thoughts like demons were after me".

Because the drug use continued, Mr. X subsequently was arrested again and again for robbery and burglary. All this time Mr. X reports that he was experiencing great difficulty with his aunt. They would argue and on at least one occasion he had threatened her life. Although he denied ever striking her, he admits to "telling her I would". After he was

arrested the last time for burglary and sentence to 6 years, his aunt took measures to have him not return to that place of residence leaving him essentially homeless.

While serving time for burglary, towards the end of his sentence Mr. X began to complain of hearing voices and noises at night. He was at that time diagnosed as being Schizophrenic Paranoid Type and started on antipsychotic medication. Just prior to completion of his sentence Mr. X began displaying overt signs of psychosis. He became irrational, episodically belligerent and verbalized that there were several plots to kill him. These symptoms persisted and upon completion of his sentence, Mr. X was admitted to GMHI for treatment. This would represent the first structured form of treatment for Mr. X, who now is 36 years old with only a fourth grade education, a long history of criminal activity and drug use, and he is homeless.

After being evaluated and assessed by the psychiatrist on unit 6 (forensic services), his diagnosis was change to Psychoactive Drug Induced Delusional Disorder. His behavior was soon stabilize and he began to actually participate in his treatment. His behavior had improved dramatically and in fat, there was not one incident of violence involving Mr. X. However, he began exhibiting extreme isolativeness and social withdrawal, and had sabotaged at least two attempts at discharge by verbalizing suicidal ideation.

## Presenting Problem and Hypothesis

The focus of this study is the patient's inability to function outside of the hospital setting due to long-term institutionalization. More specifically, the patient's sabotaging discharge effort because of an agoraphobic response to separation from the hospital. Therefore, the recognized presenting problem is the patient's irrational fear of failing therefore returning to the correctional system and in the patients words "being dead from it all". This fear was real for the patient, therefore it should be clear that any attempt to address it should be based in the reality that what is perceived as real and concrete to the patient, is real and should be treated as such. That is not to say that one should find oneself entertaining the hallucinations of the psychotic, but the threat to the patient is manifested in real behavior and it is these behaviors that cause problems in community settings.

It is proposed that at the core of the patient's dysfunction is an agoraphobic reaction response brought on by anticipated separation from the hospital. Therefore it is hypothesized that if the extent to which anxiety is experienced by a long-term hospitalized patient upon discharge has a direct and positive relationship to the relative success or failure of discharge planning. This implies that as the intensity of the anxiety increases, so to does the potential for failure upon discharge.

It is further hypothesized that to the extent that a patient is exposed to therapeutic intervention such as a level system, day treatment, dedicated casemanagement, and residential treatment, the potential for successful return to the community is greatly increased.

An effective strategy that aids in an organized measurable approach is the Individualized Treatment Plan. The treatment plan is the central coordinating document for treatment planning. It seems to record the interdisciplinary team process. It also directs the staff treating the patient to other, more specific, parts of the treatment plan. The document evolves during the stay of the patient and can be modified to the time of discharge.[2]

## Interventions and Outcome

After a clear baseline was established, the intervention phase of single system research design is at hand. The treatment plan developed by the author (the assigned social worker) called for an approach that addressed the patient's agoraphobic reaction to discharge while effecting a cognitive change in the patient's perception of his ability to function in an open community.

The first intervention introduced was the therapeutic level system. The level system is designed to reinforce positive, responsible behavior by increasing the patient's privileges as the patient demonstrates his ability to behave

responsibly. The patients environment is also gradually less restricted. Initially, the patient begins on level I. At this level, the patient is restricted to the actual unit. He has no off unit free time and his schedule is arranged by staff. Also on level I, the patient may not have passes away from the hospital. He must attend all unit activities, community meetings, and take his meals on the unit. After demonstrating that he can function well with limited supervision at level I, level II is granted.

At level II, the patient may have the privilege of leaving the unit with a staff member, although he must remain within five yards of the staff member. He may take his meals in the cafeteria with a staff escort and may attend campus wide activities. Again, when a level of responsible behavior is demonstrated, the next level is granted.

At level III, the patient may actually leave the unit without staff escort. However, he must be with a peer on level III or IV at all times. They may leave the unit for 30 minute intervals and may eat their meals in the cafeteria unescorted by staff. At level III, the patient is eligible for passes with family away from the hospital.

Finally, at level IV, the patient may have the unrestricted freedom of the hospital grounds, free of staff escort or that of a peer. It is at level IV that the patient may attend off campus meetings and activities.

With all of the levels the patient is required to attend

all appropriate treatment groups and remain free of disruptive behavior while complying to the level of responsibility that accompany each level. The projected outcome is that the patient will become increasingly more responsible for his own behavior while his environment becomes increasingly less restricted.

Figure 2, in Chapter IV, clearly indicates that as the patient was able to function in an environment that was only as restrictive as his behavior allowed, his perceived anxiety associated with discharge was significantly and positively effected. As the patients privileges enabled him to safely experiment with independence, the thought of having to do just that became less of a horror.

Once the patient achieved the privileges of level III, an appropriate day treatment program was identified. This would be the next intervention introduced. The chosen program was Sams Crossing Day Treatment Center in Decatur, GA. This center was chosen because it offered dual diagnosis day treatment [dual diagnosis refers to patients with ongoing psychiatric diagnosis as well as an addictive disease such as alcoholism]. Also, the center was located adjacent to the public transit station. This meant that the patients could access the program free of staff assistance. Once the patient was accepter, his level was raised to IV to allow him unrestricted inability to attend the program. The social worker accompanied the patient on the route via bus and train

on a trail round trip run to demonstrate the correct negotiation of the route. Then on December 16, 1991 the patient left the unit for his first day of day treatment.

The purpose intended for day treatment was to create a successful association outside the hospital. There were several components involved. The patient had to negotiated correctly the city rapid transit system to and from the center. This was to reinforce his actual independence over his limited perceived independence. He had to leave the unit no later than 8:20 a.m. in order to be there on time for the first activity and morning snack. This would reinforce a routing outside GMHI's structure.

Amazingly enough, the patient responded better than anticipated. As indicated in Chapter IV, Figure 2, his anxiety response to discharge all but diminished. In fact, the patients concerns shifted from an exaggerated concern over his perceived failure and impending danger to an appropriate problem solving approach. The patient became concerned with such issues as job training, financial assistance and a permanent residence.

The assigning of a dedicated case-manager was the next scheduled intervention. A Dedicated Case-Manager is an assigned worker from the Department of Health and Mental Health from DeKalb County who would coordinate community services, assist in accessing various community services, and advocate for the patient in times of difficulties. The aim

here is to prevent unnecessary re-hospitalization, by creating a network of contacts in the community coordinated by one individual.

The patient has supposed all expectations of the social worker and treatment team. He attended on time all schedule appointments, attended day treatment free of incidents or absenteeism other than when medically necessary or at the request of the social worker. He reportedly did very well in all aspects of the day treatment program. Since the case had progressed so well, the social worker identified discharge. That facility would be Bright Beginnings Residential Center.

The procedure was that the patient would attend a two week trial visit at the center. At the end of that time, if the patient satisfied all of their criteria (on time for meetings, participation in groups, completion of assigned custodial task, proper maintenance of living area, and no drug or alcohol use), he would be accepted. On February 6, 1992, the patient left the unit for the residential center for the two week trial visit. And on February 20, 1992 the social worker contacted the center for final approval. The patient had satisfied all admitting criteria and on February 25, 1992 was successfully discharged from GMHI.

Prior to leaving on February 6, the patient completed the GCS five times. The scale was administered on five separate occasions the five consecutive days prior to the two week trial visit. Figure 1, in Chapter IV, illustrates the

dramatic change in the patients depressed state. He has progressed from being so depressed that the depression effected his daily functioning, to an individual with some adjustment difficulties who although blunted, can adjust with time and support.

## Data Collection Procedures

The data collected for this study was obtained through administering of a standardized measure, which is a tried and tested measurement instrument designed to measure the existence and extent of a given problem. The standardized measure utilized in the study the Generalized Contentment Scale.

This questionnaire is designed to measure the degree of contentment that one feels about ones life and surroundings. The scale, GCS, was given on five different occasions on a weekly basis covering a period of five weeks from October 15, 1991 to November 5, 1991. The measure were repeated over the same time frame covering the last 5 weeks of hospitalization. The first set of measures are referred to as the baseline (pre-intervention measurement). The second set of measures identify the intervention phase of treatment. These measures are displayed in Figure 1 and are represented by "A" and "B", respectively.[3]

The Generalized Contentment Scale is reported to have internal consistency reliabilities and test-retest

reliabilities of 0.90 or better. Furthermore, it is reported as having high validity, which is the extent to which a measurement procedure actually does what it is supposed to, or measure what it's supposed to measure. In addition, the scale has good ability to discriminate between people known to have or admittedly having problems and people who are known or claim not to have problems in each area. In other words, the scale clearly appears to be measuring what it is intended to measure. The scale is short, (25 questions), easy to administer, easy to interpret, and easy to complete, easy to score, and does not appear to change merely as a result of being administered repeatedly over time (that is, they are stable).[4]

The second type of measurement tool utilized in collecting data was the Self-Anchored Scale (SAS). A SAS is a type of measurement designed by the examiner requiring the patient to rate himself. Typically, self-anchored scales are very efficiently administered, short in length, and allow specific inferences based on the actual response of the patient.

There are several steps in constructing a SAS. First prepare the client. Next, select the number of points for the scale. A seven point scale can be very useful and is effective, but fewer than five points may limit the clients ability to discriminate. Next, be sure to use equal intervals. Try to be sure that the scale you develop is only

measuring one dimension at a time. Then, anchor the scale points. Anchoring refers to the use of concrete examples to clearly define that a condition or situation is present. Next, decide when, where, and how often the measure will be given. And finally, use as repeated measures. These scales are designed to be used over time to keep track of changes in the client before, during and hopefully after intervention.[5]

Basically, both measures (GCS and SAS), were used to determine the patient's baseline. The SAS was used to obtain a progressive view of the treatment process by administering it weekly from the 15th of October of 1991 until the patient was discharged on February 25, 1992. This provided continuous assessment of the efficacy of each intervention as the case progressed.

The interventions applied in this case all have a single purpose; to increase Mr. X's ability to function independently by decreasing his perceived dependence on the hospital environment. The first step in achieving this outcome was to provide the patient with a sense of accomplishment and responsibility. A level system involving reinforcements of positive and responsible behavior was explained to Mr. X. In this level, system, once Mr. X satisfied the criteria for one level, he was raised to one of higher responsibility and less restriction. Secondly, once on a level that allowed him independent mobility about the campus, day treatment at a community based program was the next phase of discharge

planning. Here, Mr. X attended the day treatment program for eight hours during the day and returned to the hospital afterwards. Third, Mr. X was assigned to a "Dedicated Case-manager" from the County Department of Human Services. This would provide a necessary contact in the community not affiliated with the hospital. And, finally, discharge to a residential facility with rehabilitation treatment programs in place.

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# CHAPTER IV
# PRESENTATION OF FINDINGS

This chapter presents a summary of the data collected from the patient in the study. The data presented illustrates the patient's pre-intervention levels of depression and anxiety, his baseline. The data also demonstrated the effectiveness of all the interventions as they collectively improve the patients functioning.

Figure 1 graphically illustrated the patients existing depression. This baseline was established by administering the GCS over a five week period. The scale was given once per week. The average scaled score represents the patient's level of depression prior to treatment with any new interventions.

As demonstrated by Figure 1, the baseline (A) mean score is 72. This represents the patients level and extent of depression at that point in his life. This was prior to any intervention being applied. A score of 72 implies that the patient's depression has an impairing effect on the patient's ability to function within his environment. Thus, his dependence on structured care.

The depression level also implies that it is severe enough to have dramatic influences of behavior. The mean score of 72 on the GCS suggest a prevalence of hopelessness and limited adjustment abilities. This is manifested by the patients isolativeness, sporadic peer interactions, and lethargy. The patient describes his current situation as "it don't look good ... I feel like a lost cause".

Also in Figure 1, the level of depression during the intervention phase of treatment is observed. Here the mean score of 36 represents the level of depression after the patient was subjected to the therapeutic interventions. The drop in the mean scores is 36 full points, a change of 50 percent. In otherwords, the patient's level of contentment experienced a 50 percent increase after experiencing the interventions, and his level of depression correspondingly decreased.

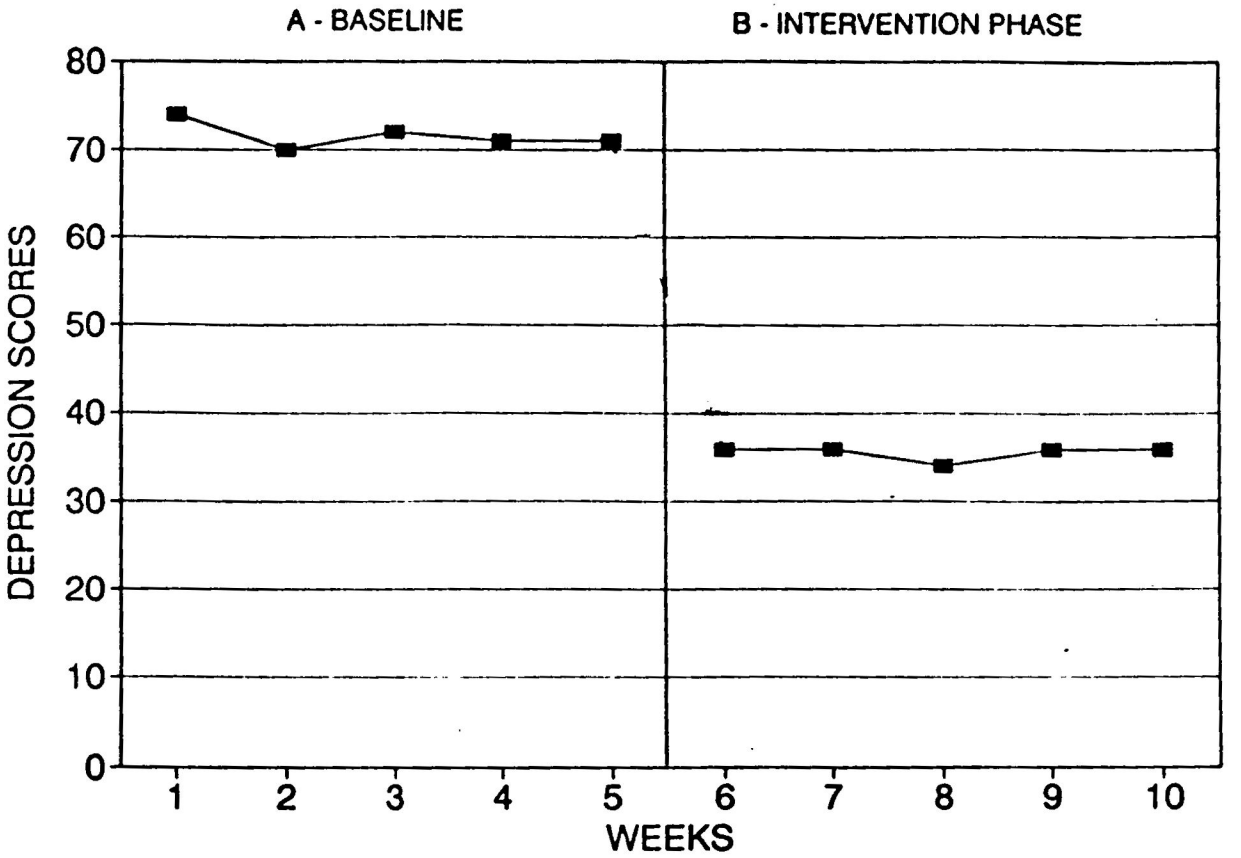


FIGURE 1. Patient's responses to Generalized Contentment Scale in Baseline and Intervention Phase.

Figure 2 presents the baseline (A) level of perceived anxiety when discharge from the hospital is mentioned. The patient was asked to assign a number to his anxiety level during interviews with the social worker. The choices were as follows:

7. Extreme Anxiety
6. High Anxiety
5. Anxious
4. Ambiguous
3. Slightly Nervous
2. Not Nervous
1. Confident

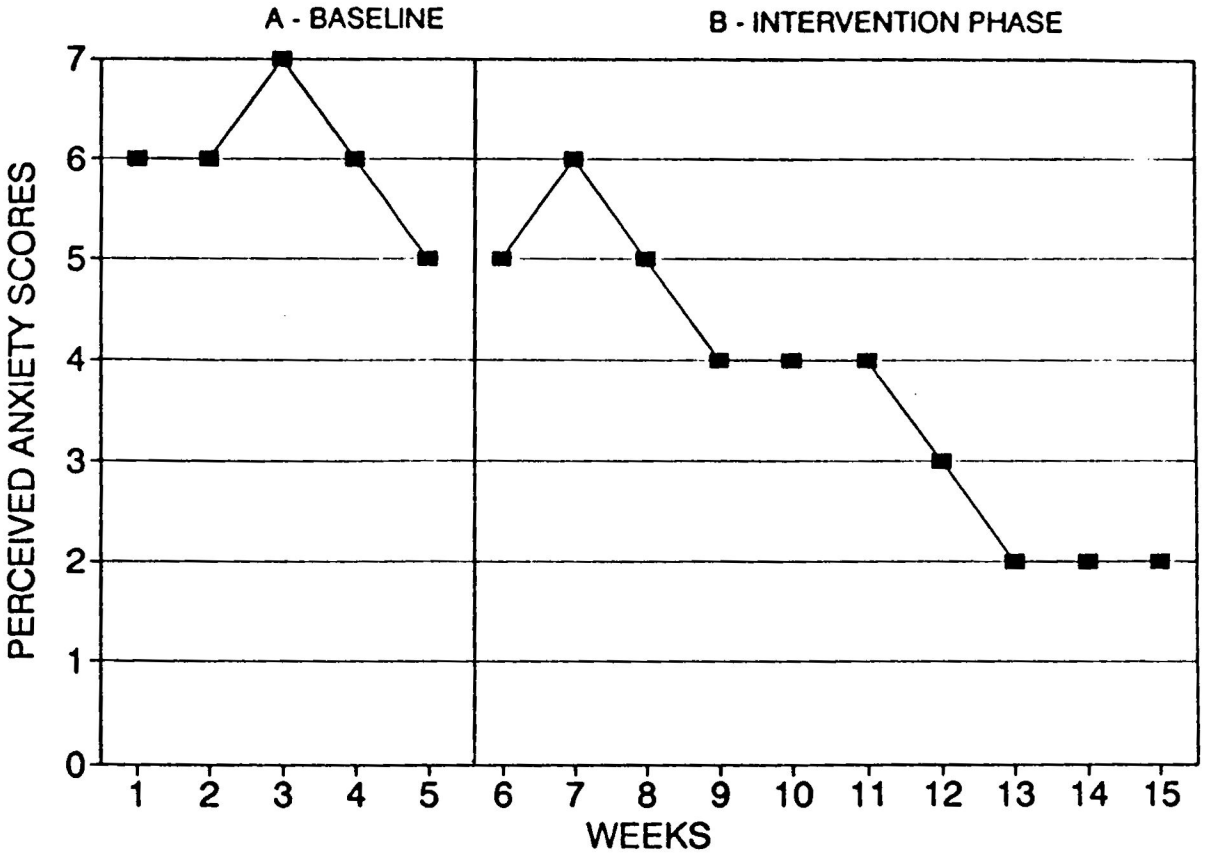


FIGURE 2. Patient's response to Self Anchored Scale in Baseline and Intervention Phase.

Figure 2 displays the intervention phase (B) and the drop in perceived anxiety is demonstrated. Where as the baseline mean score is 6, the subsequent mean score of the intervention is 4. This represents a drop of 33 percent of the original level of perceived anxiety.

Each response is designed to reflect the patient's perceived level of anxiety when confronted with separation from the hospital. The social worker would simply ask the patient to, "tell me how you would feel if you were going to be discharged from the hospital today to the community to continue your treatment out of the hospital". The patient was then asked to rate his anxiety using the seven point scale in the SAS. After the baseline was established, the patient's anxiety was measured weekly to assess the effect of the interventions. The patient presents as experiencing anxiety of an extreme nature when he is confronted with the possibility of discharge from the hospital.

## CHAPTER V
## CONCLUSIONS

The data presented in this study clearly illustrates that long term patients are better served when the effects of long term institutionalization are addressed as well as their acute illness. Although the current system at the State of Georgia isn't set up for the type of treatment provided to the patient in this study, it would be only a minor adjustment that would free up social workers to provide the quality of services for which they are trained and bound to deliver by ethics. The results indicate that when services are coordinated through mutually agreed upon objectives the patient is served better. Also the outcome of this study illustrated the importance that patient participation in the treatment process has.

The debilitating effects of long-term institutionalization have been at the heart of the problem of cycling of chronic patients. While effectively stabilizing chronic schizophrenics for eventual return to the community, the hospital creates an unrealistic sense of safety from life's stressors. This causes patients to view, although probably unconsciously hospitalization as a problem solving tool that they resort to and rely on other than strengthening the adjustment capabilities that they possess to accommodate community living.

The focus of any intervention package should consider the effect that chronic hospitalization has on discharge planning. The patient in this study verbalized that "I feel like

everybody is watching me and looking for me to mess up when I'm out of the hospital". This is a typical view of the world as seen by anyone suffering the effects of "agoraphobia". A phobia is recognized as ways of dealing with anxiety, rather than as independent pathological processes per se. Anxiety, being defined as an irrational fears of impending harm from some unknown source, is viewed as the catalyst of a phobic reaction or phobia. A phobia is defined by the GMHI Glossary of Psychiatric Terms as an obsessive, persistent, unrealistic, intense fear of an object or situation.[1]

The differences in content of the phobic thought are also generally an indication of the nature and level of anxiety the client experiences and hence can be an important clue as to the predominant level of development at which the individual is functioning. Object phobics, having to do with specific people or things (such as animals) are a representation of the predominantly sexual anxiety the genital (neurotic) client is struggling with. The danger as perceived by the neurotic client has to do with external dangers imposing on the "I" (the ego). Agoraphobic type phobias, dealing as they do with situations, circumstances, and environmental factors the client feel incapable of handling adequately, point up the anxiety around early separation and loss of the inconsistent mother figure the client has experienced. His feelings of inadequacy stem from within the self (the ego) in a situation,

not from or differentiated object (person, thing) outside the self.[2]

## Implications for Social Work

The dramatic findings of this study should force social workers within inpatient clinical settings to re-evaluate their roles as clinicians. Too often social workers are bogged down completing clerical tasks or they are limited by ridiculous job descriptions that impede the treatment process. All of the treatment outlined in this study was delivered within the GMHI system and was delivered within the existing rigid policies which generally make treatment, as described within this study, difficult. This implies that one can manipulate the system to benefit the treatment process. If others would be innovative and creative with the existing system, it will certainly change to accommodate success.

## Limitations of Study

Due to the fact that only one case was followed and this case was not typical of chronic GMHI patients, broad generalizations can not be responsibility made. Also, the patient in this study was routinely refused the services offered other patients in his situation because of his criminal background. In fact, a memo was circulated to that effect outlining in detail DeKalb County's refusal. The patient had a rape conviction 15 years prior that was overturned on appeal and one attempted rape charge. All

charges were prior to the patient receiving any formal psychiatric treatment. The social worker encountered a great deal of resistance to meeting the outlined objectives for the patient. This created time delay problems as well as personal struggles due to philosophical disagreements.

The focus of this work is on creative interventions that can significantly reduce if not eliminate the effects of long term hospitalization. Discharge planning for these individuals present social workers working with them with a difficult task. Not only should discharge be an objective, but an effective planning placement effort so as to increase the time between hospitalizations to a point where the patient's view of the hospital is more along the lines of maintenance or emergency situations only.

## Relevance to the Agency

The results of this study is probably most relevant to the clinical setting. Because of the prevalence of patients caught in similar situations, the need for an integration of inpatient and community services is obvious. Clinical social workers are in positions to initiate the type of planned change necessary for patients to receive the type of treatment required for them to effectuate some sense of normalcy.

Existing policy at GMHI dictate that social workers maintain case loads that allow minimal creative approaches to the treatment process. Social workers are often providing routine maintenance care in order to comply with rigid time

lines and are asked to complete tasks that Masters level social workers should be removed such as coordinating and accessing benefits for patients, and completing routine social histories that any Bachelor level social worker can do competently.

At the time of the study, it was difficult at best for the social worker to venture into the community due to required clerical type duties with absolute deadlines. Social worker's duties should allow enough flexibility for a variety of approaches which encourage more individualized treatment.

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# APPENDIX A

# GENERALIZED CONTENTMENT SCALE (GCS)

Name: _____ Today's Date: _____

This questionnaire is designed to measure the way you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

---

1. ____ I feel powerless to do anything about my life.
2. ____ I feel blue.
3. ____ I think about ending my life.
4. ____ I have crying spells.
5. ____ It is easy for me to enjoy myself.
6. ____ I have a hard time getting started on things that I need to do.
7. ____ I get very depressed.
8. ____ I feel there is always someone I can depend on when things get tough.
9. ____ I feel that the future looks bright for me.
10. ____ I feel downhearted.
11. ____ I feel that I am needed.
12. ____ I feel that I am appreciated by others.
13. ____ I enjoy being active and busy.
14. ____ I feel that others would be better off without me.
15. ____ I enjoy being with other people.
16. ____ I feel that it is easy for me to make decisions.
17. ____ I feel downtrodden.
18. ____ I feel terribly lonely.
19. ____ I get upset easily.
20. ____ I feel that nobody really cares about me.
21. ____ I have a full life.
22. ____ I feel that people really care about me.
23. ____ I have a great deal of fun.
24. ____ I feel great in the morning.
25. ____ I feel that my situation is hopeless.


5, 8, 9, 11, 12, 13, 15, 16, 21, 22, 23, 24

# APPENDIX B

**PERCEIVED ANXIETY SCALE**
**as presented to respondent**

How would you feel about being discharged from the hospital to the community today?

Please circle one of the following:

7. I feel like I will die
6. I feel like something bad will happen
5. I feel very nervous and can't think straight
4. I don't know how I feel
3. I feel afraid
2. I feel o.k. about leaving
1. I feel ready to leave

1 7
No Anxiety Extreme Anxiety

**ANCHORED CODES**
**to respondents response to scale**

7. Extreme debilitating anxiety
6. Very high anxiety
5. Anxiousness
4. Ambiguous
3. Nervous but able to cope
2. No nervousness
1. Confident about outcome

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